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Rep. Charlie Brown
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Sen. Robert Meeks
Sen. Gary Dillon
Sen. Connie Sipes
Sen. Billie Breaux
Sen. Vi Simpson

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date:	**September 26, 2006**
Meeting Time:	**1:30 P.M.**
Meeting Place:	**State House, 200 W. Washington St., House Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Rep. Timothy Brown, Chairperson; Rep. Mary Kay Budak; Rep. Suzanne Crouch; Rep. Charlie Brown; Rep. William Crawford; Rep. Peggy Welch; Sen. Patricia Miller; Sen. Robert Meeks; Sen. Gary Dillon; Sen. Connie Sipes; Sen. Billie Breaux.**

Members Absent: **Sen. Vi Simpson.**

The second meeting of the Select Joint Commission on Medicaid Oversight was called to order at 1:45 pm by the Chairman, Rep. Tim Brown. Rep. Brown stated that the agenda would be taken out of order and recognized Mr. John Willey of Anthem Blue Cross and Blue Shield.

Medicaid Reimbursement Issues -

Mr. John Willey, Anthem Blue Cross and Blue Shield, introduced Mr. Chad Westover, Director of Government Accounts for WellPoint, Inc., to make the presentation.

Mr. Westover, after introducing two members of his Indiana staff who were in attendance, provided the Commission with a slide presentation (see Exhibit A). Mr. Westover spoke on the participation of Anthem Insurance Companies, Inc., (a subsidiary of WellPoint) as one of the

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

three managed care organizations (MCOs) selected to provide services to Indiana's Medicaid program (in addition to Managed Health Services and MDwise, Inc.).

Mr. Westover stated that WellPoint is the nation's largest Medicaid managed care company partnering with more than 50,000 healthcare providers nationwide and having more than two million members across 14 states. He added that WellPoint would have eight community resource centers providing services in all regions of the state, along with a regional operations center with approximately 265 employees. He stated that his company would be providing a comprehensive provider network with traditional and safety-net providers and clinics, along with behavioral health, prescription drugs, and vision services. Mr. Westover indicated that his company's implementation of the managed care organization in Indiana was on track.

Chairman Tim Brown asked Mitch Roob, Secretary of Family and Social Services, to explain what the cost would be to make the Medicaid reimbursement rates provided in the Primary Care Case Management (PCCM) program consistent with Medicare physician reimbursement rates. Mr. Roob stated that the total cost would be approximately $160 M per year, with a state share of $61 M. Doing the same in the Risk-Based Managed Care (RBMC) program, in addition to the PCCM program, would cost three to four times that amount. He added that the administration will be proposing a Medicaid budget that will include a targeted increase in physician reimbursement rates, but not an across-the-board increase to all physicians.

Mr. Roob added that current managed care capitation rates are determined actuarially based on shadow claims submitted by the MCOs to the Office of Medicaid Policy and Planning (OMPP). Within the capitated rate paid to the MCOs, the Medicaid fee schedule for physician fees is the minimum amount that the doctors can be paid. The MCOs then determine the structure and amount of reimbursement for physicians within their contracts with the individual providers.

Rep. Tim Brown indicated that he would like the focus of the Commission's discussion to be on the Medicaid rates, rather than on the bidding process used in selection of the MCOs.

Chris Burke,MD, Indiana Chapter of American College of Emergency Physicians -

Dr. Burke stated that access will be the key issue in Medicaid if physicians withdraw from the program. He stated that there has already been an increase in the number of Medicaid recipients presenting for care in emergency rooms. Medicaid rates for physicians haven't changed since 1989 and are ranked near the bottom in comparison to those in other states. Dr. Burke added that MCOs frequently deny reimbursement for emergency room care provided on the basis that it does not meet the "prudent layperson" standard. Dr. Burke described the dilemma that emergency room physicians find themselves in between federal EMTALA requirements, patient demands, and third-party payers.

Chairman Tim Brown requested OMPP to provide any data they might have showing trends for the last five years in emergency room visits in the Medicaid program.

Cynthia Nassim, MD

Dr. Nassim stated that her pediatric group practice in the New Albany area has an open Medicaid panel and despite the low reimbursement serves over 2,000 Medicaid patients. She commented that, to date, none of the three MCOs selected during the recent bid process have a business presence in southern Indiana and that she has not been contacted by the new

MCOs, much less seen a proposed contract. She added that if the proposed reimbursement rates resulted in a reduction of 32% from the current level, her practice will have three alternatives: (1) continue providing services at rates that are too low, (2) close their panel, limiting the number of Medicaid patients they see, or (3) exit the program entirely. She commented that the radical change in the MCOs serving the area would result in disruption of patient care. She further objected that providers had not been consulted in the bid process and asked that Harmony and the other existing MCOs be allowed to continue to participate in the Medicaid risk-based managed care program.

Committee discussion followed regarding the disparity between the cost of providing service, private pay rates, and Medicaid reimbursement.

Jeb Teichman, MD

Dr. Jeb Teichman stated that he is a pediatrician practicing in Evansville serving 550 Medicaid children (20% of his practice). He has closed his panel in order to preserve access for current patients because he could not continue shifting costs to his private-pay patients to cover the deficits due to low Medicaid reimbursement. He commented that reimbursements are stagnant from all sources of payment, with Medicaid paying less than 50% of the lowest commercial insurance payment. He added that according to a survey conducted by the American Academy of Pediatrics, Indiana ranks 44th in the nation for Medicaid physician reimbursement. He indicated that Medicaid patients are more expensive to care for - accounting for 75% of after-hours calls, 95% of pharmacy call-backs, and 85% of missed appointments.

Dr. Teichman indicated that physicians are being encouraged to contract with more than one MCO, but doing so would significantly increase administrative costs, and he cannot afford to do that. He further stated that the typical offer for reimbursement rates from the new MCO is 103% to 105% of the current Medicaid fee schedule. Dr. Teichman stated that access to care is a reflection of reimbursement and concluded his remarks by asking where Medicaid children will get care if physicians cannot afford to see them?

Greg Hill, MD

Dr. Hill introduced himself as a family practitioner from Logansport; his practice serves about 6,000 Medicaid patients. He stated that his overhead cost is $30 per visit; the proposed Medicaid reimbursement would be about $26 per visit. He added that if physicians cannot cover their costs, they will be unable to accept Medicaid patients, forcing them to seek care in emergency departments. Dr. Hill commented that Medicaid paperwork is burdensome and objected to the take-it-or-leave-it attitude with which the new contracts were being presented to providers. He added that Logansport Memorial Hospital was reportedly not contracting with any Medicaid MCO. Dr. Hill asked that the current MCOs be left in place.

Commission discussion followed concerning how the physician payment is determined within the MCO contract and whether the Medicaid fee-for-service rate structure would have to change in order to improve the payment to the doctors. There was additional discussion on the issue of how MCOs reimburse for emergency department services.

Dan Eichenberger, MD

Dr. Eichenberger practices internal medicine in a group practice located in Floyd County. He

stated that his practice, with the exception of the pediatrician, has discontinued seeing Medicaid patients due to the burdensome paperwork and low reimbursement. He commented that managed care did not appear to work to keep Medicaid patients out of the emergency room; it just doesn't reimburse the ER doctors. He said that patients need to be responsible and to feel some cost for the services they receive; free services are valued accordingly. Dr. Eichenberger suggested that the changes being implemented will not fix the existing problems in the program, so the state should leave the existing MCO contracts in place and add the new MCO contractors.

Commission questions and discussion centered on why there was such resistance to the change in MCO contracts, what the extent of the problem was, and whether southern Indiana was more affected than central and northern areas of the state. Concern was expressed regarding OMPP's ability to get doctors and other providers enrolled in the MCOs and about 200,000 patients shifted to the new MCOs. Chairman Tim Brown pointed out that while the startup of the new contracts is January 1, 2007, the deadline for signed provider contracts is November 1, 2006.

Charles Coats, MD

Dr. Coats addressed issues of capitation contracts with an existing MCO. He described the circumstances of the situation his practice has encountered and commented that the contracts were not clear on what risk the physician was actually assuming and whether the physician had any control over the risk assumed. He suggested that by limiting the number of MCOs, the state had reduced the need for the MCOs to compete for physician services.

Hector Perez, MD, and Marie Kolp, Physician Assistant

Dr. Perez stated that he is the only Spanish-speaking physician in Fort Wayne, and that 50% of the patients he sees are Medicaid recipients. He, along with Dr. Coats, has encountered issues with the risk associated with capitation contracts signed with an existing MCO. Dr. Perez admitted that he did contract for the higher risk associated with the capitation payments, but never envisioned the kind of deficits that were encountered. He stated that it will cost him $50,000 because he provided services to Medicaid patients last year. Ms. Kolp, a law student, suggested that the contracts were confusing and should be required to be written in plain English. She reviewed points other speakers had made about the new MCO providers and commented that physicians' offices need to concentrate on educating their patients on health care and disease states - not new MCO requirements.

William Beyer

Mr. Beyer introduced himself as the Chief Operating Officer of IMA, a multi-specialty group practice in Monroe County. He stated that IMA is the primary Hoosier Healthwise provider in Monroe County. Mr. Beyer questioned the propriety of altering the bidding process and contracting with three statewide MCOs when the request for proposal (RFP) indicated the state was seeking to establish local MCOs in eight regions of the state and one statewide MCO carrier. He commented that many medical groups have had MCO contracts that set reimbursement at 130% or more of the Medicaid fee schedule and that the new MCO contractors suggest that the ability to contract with more than one MCO is a benefit that offsets their much lower reimbursement percentages. Mr. Beyer noted that medical groups are not interested in contracting with more MCOs - they want simplification; not more complexity. Mr.

Beyer asked, if the state isn't saving any money on these new contracts, and the doctors are being paid less, where is the money going?

Carmen Howard

Ms. Howard works for a medical practice in Warsaw. She stated that Medicaid patients take more time than other patients while the reimbursement is not sufficient to pay the cost. Ms. Howard asked, if the doctors cannot afford to continue to accept low Medicaid reimbursement, where do the patients go for care?

Alexandra Ude, Mercy Family Health Center

Ms. Ude stated that only five doctors in Kokomo accept Medicaid. She observed that her experience with the new contractors was that Anthem approached them with a nonnegotiable offer and that MHS has yet to schedule an appointment. She said the Mercy Family Health Center serves 55%Medicaid patients and could not survive on the 103% of the Medicaid fee schedule offered by Anthem. She commented that it makes no sense from the doctor's perspective to contract with more than one MCO. Ms. Ude stated that emergency departments would be flooded with Medicaid patients and asked that the existing system be left in place.

Charlotte MacBeth, MDwise

Ms. MacBeth stated that MDwise is a not-for-profit, provider-owned managed care organization. She stated that the 103% cited in earlier testimony did not apply to MDwise; MDwise believes that they can reimburse physicians up to 120% of the Medicaid fee schedule. Their provider relations staff is currently working on setting up the provider network. Ms. MacBeth commented that if the legislature were to require Medicaid to pay at Medicare physician rates, it would trigger a new actuarial study to reset the MCO capitation rates. She explained that federal law requires the capitation rates to be actuarially based.

Ms. MacBeth stated that MDwise offers three types of arrangements with physicians: (1) a contract for a certain percentage of the Medicaid fee schedule; (2) the Medicaid fee plus a per member per month management fee; or (3) a capitation arrangement with the risk limited only to primary care services under the control of the provider. Ms MacBeth said that MDwise had contacted 950 physicians in the last two weeks to start discussing the new provider contracts.

Don Blintzinger, Managed Health Services (MHS)

Mr. Blintzinger reviewed the growth of managed care in the Medicaid program. When Hoosier Healthwise was first established, there were only three MCOs in the state; one for each of three regions. Three other organizations were added later. He said that the number of MCOs included in the program is not the issue; the amount of the physician reimbursement is the problem. The Medicaid physician fee schedule has not been changed since 1989. He stated that the MCO capitation payment has a 2% profit margin built into the overall rate structure, but that the Medicaid fee schedule governs the amount built into the capitation rate for physician payments. The new MCO contracts also have requirements that reflect the FSSA Secretary's quality improvement goals. Mr. Blintzinger commented that MHS may not have contacted every provider yet, but their provider relations people are actively working on doing so. He also commented that the testimony and criticism expressed today will be relayed to MHS.

Paul Hobson, Molina Health Care

Mr. Hobson stated that Molina Health Care, a minority business enterprise, has been in business for 26 years and in Indiana since they were invited to participate in Hoosier Healthwise in 2005. He added that Molina was an unsuccessful bidder for the new MCO statewide contract and is currently involved in litigation which would limit the comments he would make. Mr. Hobson explained that reimbursement of physicians is an important issue, but the MCOs have to strike a balance between utilization of services, case management of patients, and physician reimbursement as the elements of cost within the capitation rate. Molina's approach has been to work with providers to manage acuity levels. Mr. Hobson stated that the transition to new contracts was a source of provider confusion. They are also concerned about continuity of care for their patients, the lack of negotiating ability, and reductions in the reimbursement available under the new contracts. He expressed concern regarding the impact of transitioning a large number of individuals in a short period of time on the 54,000 lives currently covered by Molina. Mr. Hobson also discussed the types of contracts Molina executed with providers and explained that the contracts are based on formulas that may not always yield desired results in an imperfect world.

Chad Westover, Director of Government Accounts, Wellpoint

Mr. Westover stated in response to the Committee discussion of MCO denials of emergency room claims on the basis of the prudent layperson rule that the Anthem MCO does not deny claims for that reason. He added that Anthem is in the process of contracting with safety-net providers and has scheduled opening the Community Services Centers; the first in February 2007. As a new contractor, Anthem currently has no Hoosier Healthwise members.

Leslie Naamon, Staff Vice-President, Anthem Blue Cross Blue Shield

Ms. Naamon explained that she is responsible for provider network development and the regional resource centers. She stated that the Anthem MCO is not the same as the commercial insurance - it is a separate program. Ms. Naamon said that of 2,400 primary care providers in the state, almost all have been visited by Anthem representatives, including the hospitals. She commented that those visits included several of the doctors who testified that they had not seen a representative and that one of these, had a signed contract. Ms. Naamon commented that the issue is really the level of physician reimbursement - it must be sustainable for the providers. She explained that initially Anthem had offered 103%, realized that there was too much resistance to that amount and reworked the contract. She stated that the current negotiating corridor is beyond 103% but declined to give specifics for competitive reasons.

Ms. Naamon stated that the physician reimbursement is based on the Medicaid fee schedule plus a negotiated percentage and an additional payment based on achievable parameters that are also program goals, such as number of children screened for blood lead levels, ER utilizations, prenatal care, etc. If a provider is in a defined group of top performers in these defined parameters, there will be an incentive payment. She also elaborated on the benefits to the providers of the eight Community Resource Centers which are intended to help providers resolve claims, help Medicaid eligibles with inappropriate ER use, among other customer services. She further added that Anthem will use electronic funds transfer to pay claims. Anthem also will not require referrals to specialists and has few prior authorization requirements.

Commission questions followed regarding how Anthem will build their patient population for the MCO. Ms. Naamon explained that OMPP assigns patients on the basis of the neediest MCO. It was further explained that, while initially the patient has the option to choose the MCO in which they wish to enroll, many do not select a provider. In this situation, the state would assign the Medicaid recipient to an MCO. There was an additional question regarding whether the Anthem contract contained a "most favored nation" clause. The response was that because the MCO is not a commercial model, this clause is not included in the Medicaid physician contracts. In response to a question about contracts with risk assumption for physicians, Ms. Naamon stated that the contracts are fee-for-service-based as described above and there is no risk-based physician arrangement.

Tim Kennedy, Indiana Hospital and Health Association

Mr. Kennedy reported that from the hospitals' perspective, it would be a good idea to increase the physician rates; either to Medicare levels or perhaps targeted increases. He explained that small local hospitals do not have the resources to assume the risk necessary to bid on regional MCO contracts. Wishard Hospital and MDwise are the exception. Mr. Kennedy stated that due to the self-funded intergovernmental transfer programs, 82% of hospital cost is currently covered. If the leveraging programs did not exist, hospitals would receive only 52% of their cost for Medicaid. (These figures exclude disproportionate share hospital (DSH) payments.) Mr. Kennedy suggested that with regard to increasing Medicaid reimbursement to ambulance service providers, there is already a statute that allows them to employ the intergovernmental transfer concept used by the hospitals.

Chairman Tim Brown commented that the Commission needed to examine the statutory requirement of an EDS claims payment update at each meeting since the requirements have changed and EDS processes mainly MCO shadow claims now.

Mitch Roob, Secretary, Family and Social Services Administration

Secretary Roob discussed the agency goals desired to be achieved within the new MCO contracts and the process followed for the RFPs. He reported that all the MCOs chose to bid on a statewide rather than a regional basis. He explained that the patient selection process within the MCO contract was changed from allowing the patient to select a primary care provider to allowing the patient to select the MCO. Previously, the patient selected the physician and the physician was allowed to be enrolled in only one MCO. Under the new contracts, physicians may be enrolled in more than one plan. This change removes the doctor's exclusivity as the party that can negotiate to bring patients to the MCO. Mr. Roob explained the quality initiatives and management improvements within the new contracts including electronic data sharing, electronic medical records, and patient outcomes data. Better data is needed to assess the performance of the MCOs; while contracts are to be designed to reward quality providers. He discussed agency plans to examine the program performance after the managed care contract transition is completed, although specialty care and care for the aged, blind, and disabled populations are the next priority areas for examination.

Discussion followed regarding the possibility of receiving enhanced federal funds for development of an electronic medical records system. Mr. Roob commented in response to the complaint that doctors were not involved in the process, that numerous hearings were held around the state soliciting parties to bid on the contracts. He expressed his confidence that

while the process may not be perfect, the transition to the new contracts will be accomplished in a timely manner.

The meeting adjourned at 5:55 pm.